THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-5183.M5

MDR Tracking Number: M5-04-0236-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-19-03

The IRO reviewed therapeutic exercises and office visit rendered from 01-29-03 through 04-30-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for therapeutic exercises and office visit. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-11-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
01/31/03	99080-73	$15.00	0.00	F	DOP	Rule	Work Status report was

04/11/03	99080-73	$15.00	0.00	F	DOP	129.5	not submitted unable to confirm service rendered therefore, reimbursement is not recommended.
05/07/03	99214	$110.00	0.00	F	$71.00	MFG E/M GR (VI)(B)	Documentation submitted support delivery of service. Recommended Reimbursement $ 71.00
TOTAL		$140.00					The requestor is entitled to reimbursement of **$71.00**

This Decision is hereby issued this 9th day of March 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 01-29-03 through 05-07-03 in this dispute.

This Order is hereby issued this 9th day of March 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

December 9, 2003

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: MDR #: M5-04-0236-01
IRO Certificate No.: IRO 5055

REVISED REPORT
Corrected services in dispute and dates of service.

___ has performed an independent review of the medical records of the above-named

case to determine medical necessity. In performing this review, ___ reviewed relevant

medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Pain Management.

Clinical History:
This 47-year-old male injured his back in a work-related accident on ___. He started having low back pain and muscle spasms. He was seen initially by a chiropractor for therapy.

His treatment has consisted of chiropractic care, physical therapy and active rehabilitation. His response to treatment has been good and he has returned to work full-duty with no restrictions.

Disputed Services:
Therapeutic exercises and office outpatient during the period of 01/29/03 through 04/30/03.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the services, treatments and therapies in dispute were medically necessary in this case.

Rationale:
This patient underwent six weeks of reasonable and necessary physical therapy, which is the standard of care in this country for an injury such as his. He responded very well to this therapy and returned to work at his usual capacity with zero pain level. The therapy he underwent was quite reasonable and necessary for this six-week period.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,